STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING _____ B. WING _____	C 06/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00174888. Complaint IN00174888 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: June 8 and 9, 2015 Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 23 Medicaid: 33 Other: 17 Total: 73 Sample: 5 Kindred Transitional Care and Rehab-Harrison was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 - 3.1 in regard to the Investigation of Complaint IN00174888.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE